



## Family or Dependent Care Subsidy

<b>Name of Claimant:</b>	<b>Local No.</b>
--------------------------	------------------

**CUPE only reimburses expenses in excess of regular fees.** (e.g. if your regular fees are \$30.00 per day and attendance at the CUPE function requires you to pay \$40.00, you would therefore claim the "excess fee" of \$10.00). **You may claim up to \$50.00 per day – receipts must be attached.** Please indicate the dates for expenses incurred, and the **excess** daily cost.

<b>Name of Function or Conference:</b>
--

DATE	COST (per day)
<b>TOTAL</b>	<b>\$</b>

Cheque to be made payable to: **Claimant**

**Local Union**

<b>Mailing Address:</b>

\_\_\_\_\_  
*Signature of Claimant*

(1) \_\_\_\_\_

(2) \_\_\_\_\_

*signatures of 2 officers of the Local,  
one of whom is not the claimant*

**This form must be completed and forwarded no later than 30 days following the dates claimed to:**  
**CUPE Ontario**  
**305 Milner Ave., Suite 801**  
**Scarborough, ON M1B 3V4**  
**Phone: (416) 299-9739 Fax: (416) 299-3480**

<b>Cheque #</b> _____
<b>Date:</b> _____